Cleveland Clinic

R. B. Turnbull Jr. M.D. WOC Nursing Education Program

**Daily Journal Entry with Chart Note & Plan of Care**

Student Name: Kelly Shemonis Day/Date: 1/22/26

Number of Clinical Hours Today: 8 Number of patients seen **4**

Care Setting: Hospital X Ambulatory Care ____ Home Care ____ Other ___

Preceptor: Jeanine Osby

Clinical Focus: Wound X Ostomy ____ Continence ____

This assignment should be WOC focused and approached as both patient documentation and critical thinking development. Complete each section of the document. Once you have completed the form, save the document by clinical date and preceptor. Submit to your Practicum Course dropbox for instructor review & feedback. Journals should be submitted to your dropbox no later than **48 hours** following the clinical experience day. See samples in course Resource area to assist you with this assignment.

**Reflection: Describe your patient encounters, types of patients seen, and any additional activities.**

Today I was in inpatient WOC with preceptor Jeanine Osby.
The first patient was a consult for intubation of the ileostomy stoma r/t suspected ileus. This was a 54-year-old female with a dx of endometrial CA, s/p surgery and loop ileostomy on 1/19/26. She was post-op day 3 with no output. We used a lubricated 16Fr catheter to intubate the stoma. I previously observed the procedure earlier in the week, but today I performed the intubation under my preceptor's supervision. This was a great experience because I was able to get a feel for the difference between resistance and easy insertion. Initially, there was some tension, but with a deep breath to relax the ABD, this subsided, and the foley advanced.
The second patient was a 45-year-old female with a sternal wound s/p debridement on 1/5/26 and placement of NPWT. Patient had dx of acute on chronic heart failure with LVAD placement. The wound was separate from the LVAD site. I will discuss this patient further in the chart note.
At 11:30, I met with the other student and 2 stoma nurses, then went to A30 for a presentation on post-op K-pouch care by 2 of the CWOCNs. I really enjoyed this. They had great slides and step-by-step directions. They also had the turbot bell and baby bottle nipple that was passed around. Very informative and helped solidify the textbook material. The third patient was scheduled for a pouch change for an ileal conduit and end colostomy with a stoma foley. This was a 70-year-old male with a history of rectal cancer who developed a rectourethral fistula following radiation therapy and abdominoperineal resection. This patient also had a PEG tube draining to gravity and a JP drain lateral to his incision site; both had universal securement devices (a very small one on the JP drain). I had not seen these small ones before, and they worked perfectly for this patient. The fourth patient was also scheduled for a pouch change. This was a 56-year-old male with a history of rectal CA and a previous Turnbull-Cutait procedure, now s/p end colostomy on. I had not heard of this procedure, but obviously recognized the name. This was a surgical technique that included a transanal colonic pull-through with a 2-stage coloanal hand-sewn anastomosis for intestinal transit reconstruction, first described in 1952 by our very own R. B. Turnbull Jr, MD, and by D. E. Cutait, MD, in Brazil during that period (Biondo et al., 2020).

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He still has swelling to the ABD and his stoma was “mushroomed”. The base of the stoma was 1 ¼”, but the aperture had to be cut to 1-3/8’’ to fit over the top of the stoma. A Hollister cera ring was applied to the base of the stoma to protect the peristomal skin, and then the Hollister 2 1/4“wafer was cut to 1-3/8” and applied.

Reference:
Biondo, S., Trenti, L., Espin, E., Bianco, F., Barrios, O., Falato, A., De Franciscis, S., Solis, A., Kreisler, E., & TURNBULL-BCN Study Group (2020). Two-stage Turnbull-Cutait pull-through coloanal anastomosis for lower rectal cancer: A randomized clinical trial. *JAMA surgery*, *155*(8), e201625. https://doi.org/10.1001/jamasurg.2020.1625

WOC nurses function as consultants and develop plans of care (POC) for other care givers as a guide to providing care in the WOC nurse’s absence. 1. select one patient who is an example of the identified specialty hours for this clinical day. 2. Write a chart note beginning with a brief, focused history and history of present illness, including why you are seeing the patient. 3. describe the visit including any physical assessment, interactions, interventions, and evaluations. 4. Complete a Braden Scale assessment if this was an inpatient encounter. 5. Identify any specific products used or recommended for use. Remember, this note reflects all that *was* ***done*** during the visit.

The plan of care reflects your direction/orders to another care provider *after* the encounter to be performed in your absence.

**Chart note:**

**Braden Risk Assessment Tool**

| | |
|---|---|
| Sensory Perception | 4 |
| Moisture | 3 |
| Activity | 3 |
| Mobility | 3 |
| Nutrition | 3 |
| Friction/Shear | 2 |
| Total | 18 |

Patient is a 45-year-old female seen for NPWT dressing change of sternal wound.
History of HTN, HLD, COPD, DM2, obesity, postpartum cardiomyopathy (2011) with subsequent end-stage HF s/p MVr, TVr, and LVAD, who presented with drive line infection involving her previously placed LVAD. I&D of the inferior border of sternal incision on 1/5 with VAC placement. Medications reviewed. DM managed with Ozempic 2mg/dose subQ weekly and oral medication: Jardiance 10mg daily, and metformin 500mg twice daily. Ht: 5’4, Wt: 310lbs BMI: 53.2. Smoking status: Never. Alcohol use: not currently. Drug use: never. Allergies: Cats. MAP:76 Temp 98.5, resp 24, SpO2 98%
Patient in bed, and agreeable to dressing change. Denies pain. Prior to removal of the VAC dressing, the Interdry textile was removed from the breast folds and pannus, and the skin was cleansed with pH-balanced no-rinse bath wipes and dried thoroughly. Skin clean, dry, and intact, no skin irritation noted. Adhesive remover used to remove the dressing at the distal aspect of the sternum. Wound irrigated with normal saline. Wound measures 1.4cm x 1.7cm x 2 cm. Wound bed 95% red, moist granulation tissue with 5% shiny pale-

yellow cartilage at center. Edges well defined, no undermining or tunneling. Periwound intact with hypopigmentation to edges and hyperpigmented skin/healed surgical scar at 12 o'clock. Less than 50ml serous pale drainage in canister. No odor.
-Wound irrigated with normal saline. Periwound cleansed with Hibiclens soap, rinsed with water, and dried. Convatec Esenta no-sting barrier film was applied to the periwound and allowed to dry. Then picture framed with a transparent drape. Wound filled with 1-piece urgotul contact layer wrapped around 1 piece coiled black foam bridged to the upper abdomen/epigastric area. Covered with transparent drape, hole cut, tract pad applied and connected to NPWT pump. Good seal obtained at -125mmHg continuous low suction. Dressing change well tolerated, no c/o pain. Tubing secured to the RLQ with a universal securement device.

Using the information from the chart note, develop a plan of care to be executed by other members of the healthcare team in your absence. Statements should be directive and holistic. Write as nursing orders.

**WOC Plan of Care (include specific products)**

Wound care:
-Sternal wound with NPWT: -125 mmHg low continuous suction; change Tues/Thurs/Sat. (every 48 to 72 hr or 3xweekly per manufacturer's guidelines)
-Change the V.A.C. canister once a week and as needed if full.
-Do not leave the V.A.C. dressing in place if the therapy unit (suction) has been stopped for more than 2 hours in a 24hr period. Remove black foam and cleanse the wound with normal saline. Loosely pack with hydrogel-impregnated gauze, cover with an adhesive foam dressing, notify the WOC team, and change daily until seen by the WOC nurse.

Prevention:
-Maintain Stryker Bed IsoTour with Blower for the low air loss feature.
-Maintain turning and repositioning system (Prevalon TAPS) when in bed.
-Maintain securement device for trac pad while NPWT is in use.
-Continue to cleanse skin fold with pH-balanced no-rinse bath wipes and dry thoroughly at least once daily.
-Maintain Interdry textile to pannus and breast folds. Place a single layer in the fold, smooth it flat, and allow a 2-inch extension exposed. Remove before bathing/cleansing the skin, and reuse the same piece for up to 5 days if clean, or until wet/soiled.
Nutrition:
-Maintain current diet and supplements as recommended by Registered Dietitian.

**Describe your thoughts related to the care provided. What would <u>you</u> have done differently**

Having a second person to assist with holding breasts/skin folds while applying the drape was very helpful. I really liked that a securement device was used to stabilize the tubing as well (I had not seen this used with a VAC before) because this patient gets up and sits in the chair frequently throughout the day.
The only additional thing I would have included was discussing nutrition with the patient (although my

preceptor has seen this patient before and may already have reviewed it with her). Malnutrition can still occur in the presence of obesity and is sometimes overlooked, and nutrition is essential for healing. Plus, if a patient is trying to lose weight, they will often restrict calories, and now would not be the time to do that. I only saw a multivitamin ordered on her med list, and one of the provider notes did say she was being followed by RD. I would have liked to have reviewed the recorded PO intake and the RD notes.

You should have a learning goal for each clinical day. What was your goal for the day? Was it met? Why or why not?

**Goals**

**What was your goal for the day?**
My goal was to participate in the care of a patient with a fistula. Unfortunately, there were no patients with fistulas at this time. I did get to work with wound and ostomy patients today, and several of our patients had tubes/lines, so I was able to practice securing tubes/lines with the universal securement device.

**What is/are your learning goal(s) for tomorrow? (Share learning goal with preceptor)**
I am hoping there will be a fistula patient tomorrow, but if not, my goal will be to assess/measure a stoma and determine an appropriate pouching system independently, and then verify with my preceptor. I would like my preceptor to observe me working independently and provide feedback on areas for improvement.

**For instructor use only. Do not remove or edit:**

| CRITICAL ELEMENTS | Completed | Missing |
|---|---|---|
| Medical record note reflects that of a specialist: | | |
| • Identifies why the patient is being seen | ✓ | |
| • Describes the encounter including assessment, interactions, any actions, education provided and responses | ✓ | |
| • Completes Braden Scale for inpatient encounter | ✓ | |
| • Includes pertinent PMH, HPI, current medications and labs | ✓ | |
| • Identifies specific products utilized/recommended for use | ✓ | |
| • Identifies overall recommendations/plan | ✓ | |
| Plan of Care Development: | | |
| • POC is focused and holistic | ✓ | |
| • WOC nursing concerns and medical conditions, co-morbidities are incorporated | ✓ | |
| • Braden subscales addressed (if pertinent) | ✓ | |
| • Statements direct care of the patient in the absence of the WOC nurse | ✓ | |
| • Directives are written as nursing orders | ✓ | |
| Thoughts Related to Visit: | | |

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| | | |
|---|---|---|
| • Critical thinking utilized to reflect on patient encounter | ✓ | |
| • Identifies alternatives/what would have done differently | ✓ | |
| Learning goal identified | ✓ | |

Reviewed by: _____ Date: _____

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